Initial Approval: October 10, 2018

CRITERIA FOR PRIOR AUTHORIZATION

Trogarzo™ (ibalizumab-uiyk)

PROVIDER GROUP: Professional

MANUAL GUIDELINES: All dosage forms of the following medications will require prior authorization.
ibalizumab-uiyk (Trogarzo™)

CRITERIA FOR INITIAL APPROVAL: (must meet all of the following)

- Patient has a diagnosis of multidrug resistant human immunodeficiency virus type 1 (HIV-1) infection.
- Patient must have experienced treatment failure with at least one antiretroviral medication from each of the following classes of antiretroviral medications:
    - Nucleoside reverse transcriptase inhibitors (NRTIs)
    - Non-nucleoside reverse transcriptase inhibitors (NNRTIs)
    - Protease inhibitors (PIs)
- Patient must have received antiretrovirals for at least 6 months and are presently failing or have recently failed their current antiretroviral therapy regimen.

LENGTH OF APPROVAL: 6 months

CRITERIA FOR RENEWAL:

- Prescriber must attest that the patient has achieved or maintained a ≥ 0.5 $\log_{10}$ decrease in viral load from baseline since starting therapy.

LENGTH OF APPROVAL: 12 months

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

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DATE

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PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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DATE